NO SURPRISE ACT

December 27th, 2020 Congress passed the "Act"
as part of the Consolidated Appropriations Act, 2021.

Hosted By:
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THE PATRIOT GROUP

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MEET YOUR HOST

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What does the NO Surprises Act do?

•The purpose of the Act is to bolster protections for consumers against surprise out-of-network bills and balance bill statements from healthcare providers

•The Act applies to all health plans, including self-insured plans effective on or after 1/1/2022, with limited exceptions (i.e., qualified small employer health reimbursement arrangements).

- Starting 1/1/2022, it will be illegal for providers to bill patients more than in-network cost share in most scenarios except ground ambulance transport.

PROHIBITIONS

OON Providers may not bill patients more than in-network cost share for:

- All out-of-network **emergency** facility and professional services;
- **Post-stabilization care** at out-of-network facilities until such tim that a patient can be safely transferred to a different facility;
- **Air ambulance transports**, whether emergency or non-emergency in nature;
- **Out-of-network services** delivered at or ordered from an **in-network facility** unless the patient waives the federal protection. (The ACT will NOT apply for services at out-of-network facilities).
  - Patients can **waive federal protection** except where services are urgent, unforeseen, provider is ancillary provider or there is no in-network provider at facility.

Regarding Surprise Medical Billing

Section 102

Health Insurance Requirements

Section 103

Independent Dispute Resolution

Section 104

Provider Requirements

Section 102 - Health Insurance Requirements

Out-of-Network Provider, In-Network Facility,

and Failure to Satisfy Notice & Consent Requirements and RATES.

NOTICES

- If Notice NOT Given: Cost-Sharing responsibility of the patient shall be the **same** as if the services were provided by an **in-network provider**.

RATES CRITICAL CONSIDERATIONS

- Act does not provide a benchmark payment standard as the insurers requested.
- Cost-sharing to be based on the “Recognized Amount”.
- Medicare, Medicare and other Government rates cannot be considered.
- Billed Charges Cannot be considered.
- UCR cannot be considered.

Section 103: Dispute Resolution and the IDR Process (Overview)

• When insufficient reimbursement or notice of denial is received, providers are entitled to challenge the determination through the "baseball-style" independent dispute resolution (IDR) process, absent certain exceptions (as noted herein).

>> STEP 1 Initiate "**Open Negotiations**" within 30 days of receipt of payment or notice of denial.

>> STEP 2 If Open Negotiation Fails, initiate the IDR Process **within 4 days** of the end of the 30-day open negotiation period.

>> STEP 3 Select the IDR Entity (*i.e.*, the arbitrator)

>> STEP 4 Submit the amount(s) desired and any supporting evidence or documentation required.

>> STEP 5 Await determination (**30 days from selection of IDR entity**).

Dispute Resolution and the IDR: Open Negotiation

• The provider or facility (or plan or coverage) has **30 days from the receipt** of payment or notice of denial to initiate the open negotiation period.

-It is anticipated that the HHS Secretary will promulgate rules and/or regulation - underlying the process for formerly initiating open negotiation.

• The open negotiation period can last for **up to 30 days**.

• Even if IDR is initiated, open negotiations may continue.

Dispute Resolution and the IDR: Selection of IDR Entity

- The parties (*i.e.*, the provider/facility and the plan/coverage) have **3 business days** from the initiation of the IDR process to jointly select the IDR entity (*i.e.*, the arbitrator).

- If the parties fail to agree on the IDR entity, the HHS Secretary shall select the IDR entity within **6 business days** from the initiation of the IDR process.

- The IDR entity cannot have a conflict with either of the parties. For example, the IDR entity cannot be an employee or agent of a party; cannot have a material familial, financial, or professional relationship with a party; and cannot have any other conflict of interest.

Dispute Resolution and the IDR: Initiation & Batching of Claims

- **Within 4 days** of the expiration of the 30-day open negotiation period, the provider or facility (or plan or coverage) can initiate the IDR process
    - IDR is initiated by issuing notice to the other party **and** the HHS Secretary.
- Notably, claims can be **batched** (combined into 1 IDR) if:
    - The services were furnished by the same provider or facility;
    - Payment is required by the same insurance plan or issuer;
    - The services are related to treatment of a similar condition; and
    - The services were provided during the 30-day period from the date that the 1st service(s) was provided.

Dispute Resolution and the IDR: Submission of Desired Amount

- The parties must submit their respective offers (desired amounts), along with any supporting evidence or documentation, **within 10 days from the selection of the IDR entity**.

- As noted above, the IDR process is a "**baseball-style**" arbitration, meaning each side submits an offer and the IDR entity must choose 1 of those 2 offer amounts.
  - The IDR entity is prohibited from averaging the 2 offer amounts or otherwise choosing any other amount except for 1 of the 2 offer amounts submitted by the parties.

- Setting an appropriate amount will incentivize the payor to act reasonably in the future.
  - The payor will not want to continuously pay IDR charges over and above the reimbursement payment amount, thereby minimizing delay to your revenue cycle.

Dispute Resolution and the IDR: Permitted Considerations

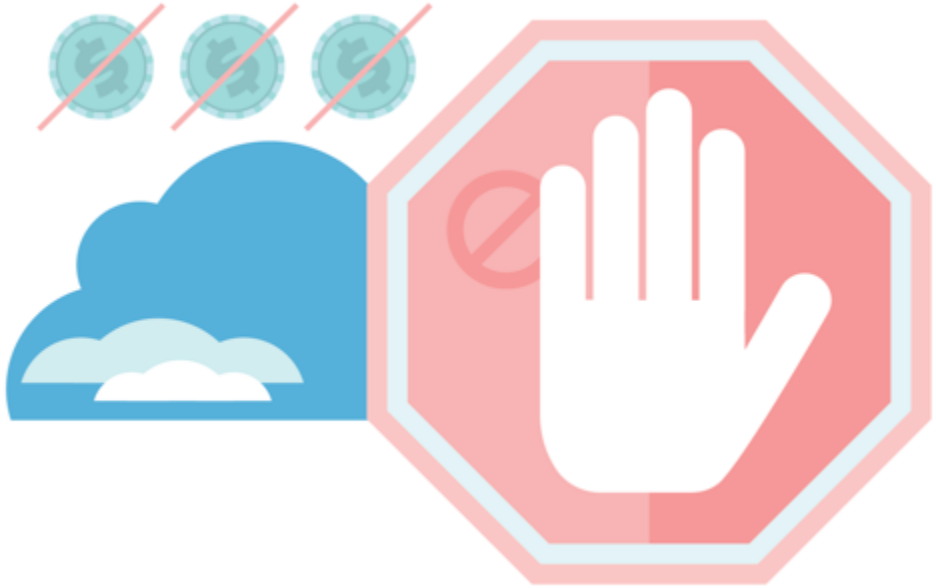
In making its determination, the IDR may consider:

- The information requested and received by the IDR entity;
- Qualifying Payment Amounts of the applicable year for comparable services in the same geographic region; and

- Other considerations, such as:
  - Training, experience, quality and outcome measurements of the provider;
  - The market share held by the provider for the geographic region;
  - The acuity of the patient and complexity of the care provided;
  - The good faith efforts of the provider to enter into a network agreement and, if applicable, contracted rates of the parties during the previous 4 plan years.

Dispute Resolution and the IDR: Prohibited Considerations

- In making its determination, the IDR entity is **prohibited from considering**:
  - Usual/customary charges for the service(s);
  - The Billed Charges; and
  - Reimbursement rates of public payors, such as: Medicare, Medicaid, etc.



Dispute Resolution and the IDR: Determination

- The IDR entity has **30 days** from its selection to make a determination.
- Importantly, the IDR entity's determination is binding and not subject to judicial review (absent a fraudulent claim or evidence of misrepresentation of facts to the IDR entity).
- The Payor has **30 days** from the determination to issue the required payment.

Dispute Resolution and the IDR: Other Key Considerations

To deter excessive use of the IDR process, the Act includes 2 other key aspects that should be taken into account:

- **Payment of the IDR Entity's Fees**: The party whose amount is not selected by the IDR entity (*i.e.*, the losing party) will be responsible for paying all fees charged by the IDR entity.

  -However, in the event that the parties come to an agreement after initiating the IDR process (but prior to a determination), each party shall pay 50% of the fees charged by the IDR entity, unless the parties agree otherwise.

- **Waiting Period**: There is a **90-day waiting period** ("cooling off period") from a determination that prohibits a party from initiating IDR against the other same party, with respect to such an item or service.

Dispute Resolution and the IDR: When is IDR unavailable?

An OON provider who performed non-emergency services at an in-network facility **may NOT Arbitrate** if:

- The provider has **satisfied the notice and consent** requirements; or
- The services are an "**ancillary service**" (radiologist, anesthesiologist , pathologist)
- No network provider available at the facility.

Section 104 – Provider Requirements
The Bottom Line

The crux of this section is the OON provider shall not bill, and shall not hold liable, a patient for a service that is more than the in-network cost-sharing requirements for such service (see Prohibitions Slide).

Section 104 – Provider Requirements
Required Notice & Consent (General)

Notice: At least 72 hours prior to the date on which the services are to be rendered - The written notice is to be made available in **the 15 most common languages** in the geographic region of the facility.

Consent: Must be signed and dated prior to the rendering of services.

See sample of disclosure showing requirements

Section 104 – Provider Requirements
Notice & Consent (General –Continued-)

• The Notice and Consent are to be held for 7 years from the date of service.

• Notice and consent requirement does NOT apply to any services provided as a result of unforeseen urgent medical needs that arise at the time the covered service is provided.

• Likewise, the Notice and Consent process cannot be utilized if there is no in-network provider available to furnish the item or service (i.e., deemed an “ancillary service”).

Section 104 – Provider Requirements Notice (Specifics)

Format of notice (paper or electronic) to be selected by the patient.

- The **Notice must contain**:
  - A ***clear statement*** that consent to receiving services is optional;
  - A ***clear statement*** that the patient may seek care from an in-network provider (and the affect this would have on his/her cost-share)
  - ***Notification*** that the provider is OON
  - A ***good faith estimate*** of the amount that the provider may charge;
  - ***Notification*** that the estimate/consent is not a contract;
  - A ***list of in-network providers at the facility***;
  - ***Notification*** that the patient can be referred to an in-network provider; and
  - Information ***whether prior authorization*** or ***other limitations*** are required.

Section 104 – Provider Requirements
Consent (Specifics)

The Consent must be <u>signed prior</u> to the services being provided

- The **<u>Consent must contain</u>** the following:
  - ***Patient Acknowledgement*** that:
    - He/she was provided with the required notice;
    - He/she was informed that payment may not go toward cost-sharing limitations, including the in-network deductible; and
    - He/she was provided with the opportunity to receive notice in the form he/she selected.
  - The ***date*** the patient ***received the Notice***; and
  - The ***date*** the patient ***signed the Consent***.

<u>Note:</u>

The consent shall not constitute a contractual agreement for the payment of the estimated charges.

Section 104 – Provider Requirements
Posting of Patients' rights

- Commencing January 1, 2022, all healthcare providers **must** make publicly available information on patients' rights with respect to balance billing.
- Such notice should be available or posted on the provider's public website and **must** contain:
  - Information on the requirements established under the Act;
  - Information on any state-level protections, if applicable; and
  - Contact information for state and federal agencies to report any potential violations.

Additional Aspects of the Act

- State law continues to be applicable (and is not superseded by the Act) with regard to state-established payment amounts and mechanisms for certain services.

- Uninsured patients are afforded protections under Section 112 of the Act.
  - Such patients are permitted to initiate a dispute resolution process if they believe the amount actually billed was substantially in excess of the estimate issued by the provider or facility.

Additional Aspects of the Act
Section 112 – Good Faith Estimates

- The Act requires healthcare providers (including both individual practitioners and facilities) to share ***"good faith estimates" of the total expected charges*** for scheduled items or services, including any expected ancillary services, with:
  - The health plan (if the patient is insured); or
  - The individual (if the patient is uninsured).

Additional Aspects of the Act
Section 111 – Advanced EOBs

- The Act requires health plans to provide Advanced EOBs, which are triggered by the provider's or facility's provision of a "good faith estimate".
- The Advanced EOB is to include, among other items:
  - "Good faith estimate" of the plan's payment responsibility;
  - "Good faith estimate" of the patient's expected cost-sharing amount (based on the notification date and not the date of service); and
  - "Good faith estimate" of the amount the patient has incurred toward meeting their financial responsibility limits (*i.e.*, deductible and out-of-pocket maximums).

Additional Aspects of the Act
Section 111 – Advanced EOBs –Continued-

The Advanced EOB is to be provided within:

3 business days, if the service is scheduled at least 10 business days after the plan receives a request from an Advanced EOB or notice that the service has been scheduled; or

1 business day, if the service was scheduled less than 10 days after the plan receives a request from an Advanced EOB or notice that the service has been scheduled.

Additional Aspects of the Act

Can a patient be balance billed if he/she goes to the emergency room?

Short Answer: **No**, the patient cannot be balance billed if the services are furnished by an OON provider at the hospital or emergency department.

- This determination is based on § 104 of the Act, which, for purposes of the Public Health Service Act ("PHSA"), expressly includes this prohibition under § 2799B-1 ("Balancing Billing in Cases of Emergency Services").
- Per this section, under such circumstances, the patient cannot be billed more than the cost-sharing requirements for such services.

✓ Notwithstanding the above, it is possible this prohibition will be changed by agency rule, as § 2799B-2 of the PHSA ("Balance Billing in Cases of Non-Emergency Services…") contains contradictory language, namely the inclusion of emergency medicine and anesthesia, among areas of medicine, under "Ancillary Services".

Key Takeaways

- The anticipated effects of the Act are fluid, as rules will be promulgated by HHS, in conjunction with the Departments of Labor and the Treasury throughout 2021.
  - These rules could drastically alter the structure and effects of the Act *(e.g.*, penalties for noncompliance with the notice & consent structure; penalties for failing to negotiate in good faith; what other services are considered “ancillary services”, etc.).

- ***Thus, it is important to secure appropriate advice as new rules, regulations, and guidance are provided***

- ***The Patriot Group and The Force Law Firm are here to help you navigate this uncertainty.***

Key Takeaways -Continued-

- Depending on the rules, regulations, and guidance promulgated, an OON provider that provides services at an in-network facility may want to consider whether it makes sense financially to issue notice/secure consent or refrain from doing so to be permitted to utilize the IDR process.

    - ***In this regard, the promulgated rules and regulations will be of particular importance, as the Act speaks to civil penalties of $10,000 per violation of the requirements. However, per the statute's language, there is no requirement to issue notice or secure consent if a provider does not intend to balance bill.***

- If utilizing the IDR process, submitting the appropriate payment amount may not only result in a positive outcome for a selected case, but may also cause payors to be weary of entering the process (and paying additional fees) in the future, promoting fairer negotiations.

Deadlines for Regulation Promulgation & Guidance

July 1, 2021:

-HHS to establish the “qualifying amount”

-HHS to provide guidance on Notice and Consent

October 1, 2021:

-HHS to establish the health plan audit process

December 27, 2021

-HHS, DOL, and Treasury to establish the IDR process.

January 1, 2022:

-HHS and DOL to establish consumer complaint process.

-HHS, DOL, and Treasury to issue rules for protection against provider discrimination.

-HHS to establish the patient-provider dispute resolution process

Additional Deadlines & Important Reporting Dates

January 1, 2023:

-GAO to report on Provider Network Accuracy

December 1, 2023:

-GAO to report on the IDR Process

January 1, 2025:

-GAO to report on the implications of the Act

No Set Date:

-HHS's provision of timing requirements for Advanced EOBs for services having low utilization or significant variations in cost.

THANK YOU!

Q&A

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